Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 27, 2017	2017_486653_0013	014730-16, 020144-16, 035015-16, 001596-17, 007291-17	Complaint

Licensee/Titulaire de permis

THE JEWISH HOME FOR THE AGED
3560 BATHURST STREET NORTH YORK ON M6A 2E1

Long-Term Care Home/Foyer de soins de longue durée

THE JEWISH HOME FOR THE AGED (2824)
3560 BATHURST STREET NORTH YORK ON M6A 2E1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ROMELA VILLASPIR (653), NICOLE RANGER (189), NITAL SHETH (500), SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 30, and July 4, 5, 6, 2017.

The following were inspected concurrently during this inspection:
Complaint intakes log # (s): 014730-16, 020144-16, 035015-16, 001596-17, 007291-17.

During the course of the inspection, the inspector (s) conducted a tour of the resident home areas, observed staff to resident interactions, reviewed clinical health records, staff training records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Administrative Assistant (AA), Housekeeping Aides (HKAs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Advanced Practice Nurse (APN), Social Workers (SWs), Physiotherapist (PT), Occupational Therapist (OT), Registered Dietitian (RD), Physicians, Unit Director, Unit Manager, Supervisor of Environmental Services, Environmental Services Manager (ESM), Human Resources Business Partner, Manager for Human Resources, Executive Director of Human Resources, Client Relations Officer, Medical Director, Associate Director of Care and Resident Experience (ADOC), and the Director of Care and Resident Experience (DOC).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of the residents were fully respected and promoted: Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act 2004, kept confidential in accordance with that Act.

While conducting an inspection related to an allegation of retaliation from the home to a staff member, Human Resources Business Partner (HRBP) #125 informed the inspector of an anonymous letter that was found on the 3rd floor by Personal Support Worker (PSW) #101. The letter outlined that resident #016 had an identified medical condition. The inspector reviewed the letter which further stated that the managers were withholding this information from the staff, and that PSW #101 should get himself/ herself tested and find a lawyer. HRBP #125 revealed that the Human Resources department received the letter on an identified date.

Interview with PSW #101 revealed that on an identified date, on an identified unit, PSW #136 was sitting at the nursing station and requested PSW #101 to pass his/ her handbag which was located in the cupboard above the sink. PSW #101 reported that he/ she gave PSW #136 his/ her handbag, and as he/ she turned to take the garbage out, he/ she found a letter on the floor that was addressed to him/ her. PSW #101 stated that he/ she picked up the letter and did not say anything to PSW #136, and proceeded to leave the facility to go to his/ her car. PSW #101 read the letter stating resident #016 had an identified medical condition, and that the managers were withholding this information from the staff, and that PSW #101 should get himself/ herself tested and find a lawyer. PSW #101 reported this information to the Associate Director of Care and Resident Experience (ADOC).

PSW #101 reported that prior to receiving this letter on an identified date, resident #016 was sent out to the hospital. While resident #016 was still in hospital, ADOC #113 reported to the staff on an identified unit that he/ she received information from the hospital that the resident had an identified medical condition. PSW #101 reported that two days after, the ADOC #113 came back to the staff on the unit and stated that it was a mistake at the hospital and resident #016 did not have the identified medical condition. PSW #101 reported by that time, the staff on two identified units were already discussing the resident's medical condition.

The inspector reviewed the physician profile list on resident #016's chart which revealed the resident had the identified medical condition. A review of the home's investigation notes related to the allegation of abuse of resident #015, revealed that during an interview with resident #015 on an identified date, the resident reported to the Director of Care and Resident Experience (DOC) and the ADOC that he/ she was informed by Housekeeping Aide #137 that resident #016 had an identified medical condition. Interview with the DOC revealed that he/ she could not recall the interview that was conducted with the resident.

Interview with the DOC confirmed that resident #016's personal health information was not kept confidential in accordance with the Personal Health Information Protection Act 2004. [s. 3. (1) 11.]

2. On June 22, 2017, at 1013 hours (hrs), on the 2nd floor south side, inspector #116 observed a medication cart and a treatment cart in an accessible nursing station unlocked and unattended.

Several empty blister packs inscribed with the residents' names and prescribed medications were left unattended on top of the medication cart. The personal health information was visible to the public.

An interview held with Registered Nurse (RN) #128 who was assigned to the medication cart indicated that he/ she always left the empty packets on top of the medication cart to check for any medications that may have been stuck.

Further interviews held with RN #128 and the DOC confirmed that the blister packs were to be discreetly stored and discarded in a manner which protects the resident's personal health information. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint on an identified date, related to the lack of skin and wound care of resident #005.

Review of progress note on an identified date, revealed the resident had multiple skin impairments located on four identified body parts. It was also indicated that RN #156 recommended an identified treatment for one identified body part. Review of progress note on an identified date, indicated RN #156 re-assessed resident #005's multiple skin impairments, and he/ she changed the recommended treatment for one identified body part.

Review of resident #005's Treatment Administration Record (TAR) from an identified time period, revealed two treatment entries for the skin impairment on the identified body part.

Interview with Registered Practical Nurse (RPN) #141 stated that resident #005's plan of care did not provide clear directions to staff because there were two different treatment entries for the identified body part. He/ she could not recall which treatment they were following at that time.

Interview with the DOC acknowledged that the resident's plan of care did not set out clear directions to staff in regards to resident #005's treatment for the skin impairment on the identified body part. [s. 6. (1) (c)]

2. The MOHLTC received a complaint related to the personal care being provided by the staff to resident #034.

An interview held with resident #034 indicated he/ she had an identified medical condition that required an identified care and treatment device. The resident further indicated that the PSWs were not trained to provide the identified care and that the incorrect treatment device was being used on him/ her.

On an identified date, the inspector observed an identified treatment device being applied to resident #034. On two identified dates, inspector #116 observed a different size of the treatment device applied to the resident.

Review of the written plan of care and progress notes did not indicate the type and size of the treatment device to be used or the frequency the treatment device was to be changed.

Interviews held with RPN #128 and RN #160 indicated that supplies were ordered based from the inventory within the resident's room, and that they were unaware of where to obtain the appropriate treatment device to be used with resident #034.

Further interviews held with RPN #128, RN #160, ADOC and the DOC confirmed that the plan of care did not set out clear directions to staff in regards to the correct treatment device to be used to manage resident #034's identified medical condition. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the provision of care set out in the plan of care had been documented.

A review of resident #023's clinical health records revealed that there was no

documentation on his/ her personal care flow sheets for the care provided to resident #023 on two identified dates, during the night shifts.

Interviews with night RPN #194 and night PSWs #195 and #196 revealed that the night PSWs were responsible to document on the personal care flow sheets for the residents' care. Documentation should have been completed by the night shift on the two identified dates. PSW #195 indicated that there were times that staff get very busy in the night shift and were unable to complete the documentation due to lack of time.

Interviews with RPN # 152, RN #120, Unit Director #123, and Unit Manager #155 revealed that the above-mentioned documentation for care provided should be documented by the night PSWs. [s. 6. (9) 1.]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

The MOHLTC received a complaint on an identified date, related to the lack of skin and wound care of resident #005.

Review of progress note on an identified date, revealed the resident had multiple skin impairments located on four identified body parts. It was also indicated that RN #156 recommended an identified treatment for one identified body part. Review of progress note on an identified date, indicated RN #156 re-assessed resident #005's multiple skin impairments, and he/ she changed the recommended treatment for one identified body part.

Review of resident #005's Treatment Administration Record (TAR) from an identified time period, revealed two treatment entries for the skin impairment on the identified body part.

Interview with RPN #141 acknowledged that the resident's plan of care was not revised after the resident was re-assessed by the RN. He/ she further indicated that the new treatment prescribed by the RN was added on the TAR, however, the previous treatment remained on the TAR.

Interview with the DOC acknowledged that resident #005's plan of care was not updated after his/ her multiple skin impairments were re-assessed by the RN. The DOC further indicated that the plan of care was supposed to be updated. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure
-that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident;
-that the following are documented: 1. The provision of the care set out in the plan of care;
-that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee had known of, or that was reported to the licensee, was immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations; (b) appropriate action was taken in response to every such incident.

The MOHLTC received a complaint on an identified date, reporting an allegation of staff to resident abuse.

Interview with the DOC revealed that he/ she interviewed resident #015 regarding the alleged abuse, and the resident confirmed he/ she felt he/ she was abused by PSW #139, but then later recanted the story, so the DOC reported he/ she did not interview the alleged abuser PSW #139, or any other staff members.

Interview with RPN #114 revealed that resident #015 reported to him/ her of an incident that occurred between the resident and PSW #139, but the resident did not want to speak on the issue as he/ she did not want to get any staff in trouble. RPN #114 also revealed that PSW #101 discussed the incident at the nursing station and that PSW #139 pushed the resident's walker and told the resident to sit down.

Based on the information that was provided, an allegation of abuse occurred between resident #015 and PSW #139. The DOC confirmed that the allegation of abuse was not thoroughly investigated and that appropriate action was not taken in response to the incident; and any requirements that were provided for in the regulations for investigation and responding as required under clauses (a) and (b) were not complied with. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations; (b) appropriate action is taken in response to every such incident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

The MOHLTC received a complaint related to the personal care being provided by the staff to resident #034.

Resident #034 was admitted to the home on an identified date, with an identified medical condition that required an identified care.

Review of the initial admission assessment record and an interview held with Advanced Practice Nurse (APN) #163 indicated that an initial assessment was not conducted in relation to the care provisions for the identified medical condition.

A review of the resident's written plan of care and progress notes did not identify any supporting documentation in relation to the care requirements, goals or interventions for the resident's identified medical condition.

Interviews held with RN #160, RPN #168, APN #163, Nurse Manager #155, ADOC, and the DOC confirmed that the plan of care had not been developed based on an interdisciplinary assessment of the resident that included goals and interventions to reflect resident #034's need for assistance in regards to his/ her identified medical condition [s. 26. (3) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Continence, including bladder and bowel elimination, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, that skin and wound care training had been provided to all staff who provided direct care to the resident.

The MOHLTC received a complaint on an identified date, related to the lack of skin and wound care of resident #005.

A review of the home's training records in 2016, revealed 14 out of 238 PSWs and 13 out of 102 registered staff did not receive training on skin and wound care.

Interview with the DOC acknowledged that not all direct care staff were trained on skin and wound care in 2016. [s. 221. (1) 2.]

2. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, that continence care and bowel management training had been provided to all staff who provided direct care to the resident.

The MOHLTC received a complaint related to the personal care being provided by the staff to resident #034.

An interview held with resident #034 indicated concerns in regards to an identified care provided by the PSWs.

Interviews held with PSWs #157, #158 and #159 indicated that they performed the

identified care without receiving training from the home. PSW #189 indicated that although they received training within the PSW certification course, they have not been provided with onsite instruction to perform the identified care for resident (s) in the home under their care.

The home's policy indicated that only registered staff members trained with the knowledge, skill and judgment may perform the identified care. PSWs trained to use the identified treatment device may empty the device.

Review of the home's in-service training record held on January 22, 2016, revealed that all staff who provided direct care to residents with the identified medical condition did not complete the training related to the identified care provision and treatment device.

Interviews held with APN #163 and the ADOC indicated that although PSWs received training on the identified care provision as part of the PSW certification; the home's expectation was for direct care staff involved in the care of resident (s) with the identified medical condition to receive training at point of care as a delegated act.

Further interviews held with APN #163, ADOC and the DOC confirmed that not all staff who provided direct care to the residents received training on the identified care provision. [s. 221. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, training shall be provided to all staff who provide direct care to residents: Skin and wound care and continence care and bowel management, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The MOHLTC received a complaint on an identified date, related to the lack of skin and wound care of resident #005.

Interview with RN #156 confirmed that resident #005 was under the home's skin and wound care program as he/ she had multiple skin impairments.

Review of resident #005's written plan of care on two identified dates, indicated he/ she had an alteration in skin integrity. The written plan of care directed staff to provide an identified care.

Review of resident #005's personal care flow sheets on 14 different dates and various shifts revealed he/ she stayed in bed all shift, however, it was not documented whether the identified care was provided by the PSWs.

Interviews with PSWs #166 and #170 stated that the home's expectation was for PSWs to document the identified care provided to the resident on the personal care flow sheets.

Interview with the DOC acknowledged the lack of documentation from the PSWs in regards to the identified care provided on the identified dates and various shifts. He/ she further indicated that the home's expectation was for the PSWs to document the care they have provided. [s. 30. (2)]

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 31st day of July, 2017

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.